

111TH CONGRESS
2D SESSION

H. R. 5546

To provide for the establishment of a fraud, waste, and abuse detection and mitigation program for the Medicare Program under title XVIII of the Social Security Act.

IN THE HOUSE OF REPRESENTATIVES

JUNE 16, 2010

Mr. ROSKAM introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for the establishment of a fraud, waste, and abuse detection and mitigation program for the Medicare Program under title XVIII of the Social Security Act.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. MEDICARE FRAUD, WASTE, AND ABUSE PRE-**
4 **VENTION SOLUTION.**

5 (a) ESTABLISHMENT.—

6 (1) IN GENERAL.—The Secretary of Health and
7 Human Services (in this section referred to as the
8 “Secretary”) shall develop and implement a fraud,

1 waste, and abuse comprehensive pre-payment review
2 prevention system (in this section referred to as the
3 “Prevention System”) for reviewing claims for reim-
4 bursement under the Medicare Program under title
5 XVIII of the Social Security Act (in this section re-
6 ferred to as the “Medicare Program”).

7 (2) IMPLEMENTATION.—The Secretary shall
8 carry out the Prevention System acting through the
9 Center for Program Integrity of the Centers for
10 Medicare & Medicaid Services.

11 (b) SELECTION OF CLAIMS ACROSS ALL PROVIDER
12 TYPES.—The Prevention System shall cover all types of
13 providers of services and suppliers under the Medicare
14 Program, but may be limited to a subset of claim seg-
15 ments.

16 (c) SYSTEM DESIGN ELEMENTS.—To the extent
17 practicable, the Prevention System, shall—

18 (1) be holistic;

19 (2) be able to view and analyze all provider of
20 services, supplier, and patient activities from mul-
21 tiple providers of services and suppliers under the
22 Medicare Program;

23 (3) be able to be integrated into the health care
24 claims flow in existence as of the date of the enact-
25 ment of this Act with minimal effort, time, and cost;

(4) be designed to use technologies, including predictive modeling, that can utilize integrated near real-time transaction risk scoring and referral strategy capabilities to identify transactions, patterns, anomalies, and linkages that are statistically unusual or suspicious and can undertake analysis before payment is made and that prioritizes unusual or suspicious claims in terms of likelihood of potential fraud, waste, or abuse to more efficiently utilize investigative resources;

(5) be designed to—

(A) allow for ease of integration into multiple points along the claims flow under the Medicare Program (pre-adjudication and post-adjudication of such claims) in order to demonstratively show that the system ranks the likelihood of high-risk behavior patterns and of fraud, waste, or abuse; and

(B) utilize experimental design methodology to monitor and measure the performance between the control treatments (which shall be the methods and assessments used as of the day before the date of the enactment of this Act to address fraud, waste, and abuse under the Medicare Program) and test treatments (which

1 shall be the Prevention System identification of
2 such fraud, waste, and abuse and actions taken
3 pursuant to such system to address such fraud,
4 waste, and abuse); and

5 (6) be provided through competitively bid con-
6 tracts using the Federal Acquisition Regulations.

7 (d) SYSTEM OPERATION.—

8 (1) SCORING AND NEAR REAL-TIME ANAL-
9 YSIS.—

10 (A) IN GENERAL.—The Prevention System
11 shall identify high-risk Medicare claims by scor-
12 ing all such claims in near real-time, prior to
13 the Centers for Medicare & Medicaid Services
14 making payment on such claims under the
15 Medicare Program.

16 (B) USE OF SCORES.—The scores under
17 subparagraph (A) shall be communicated to the
18 fraud management system under subsection (f).

19 (C) NEAR REAL-TIME ANALYSIS.—Under
20 the Prevention System, the near real-time anal-
21 ysis of Medicare claims data shall be conducted
22 in a manner that ensures—

23 (i) prompt identification of fraud,
24 waste, and abuse; and

1 (ii) prompt payment of legitimate
2 claims.

3 (2) PREDICTIVE MODELING.—The Prevention
4 System shall involve the implementation of a statis-
5 tically sound, empirically derived predictive modeling
6 technology that is designed to prevent fraud, waste,
7 and abuse (by identifying such fraud, waste, and
8 abuse before payment is made under the Medicare
9 Program on related claims). The Prevention System
10 shall use a predictive model to identify fraud, waste,
11 and abuse that is—

12 (A) based on historical transaction data,
13 from across all markets and regions available,
14 to build and continuously re-develop scoring
15 models that are capable of incorporating exter-
16 nal data and external models from other
17 sources into the predictive model; and

18 (B) regularly updated, through the feed-
19 back loop under subsection (g), to provide infor-
20 mation and incorporate data on reimbursement
21 claims that is collected through the Prevention
22 System, including information gathered through
23 the investigation of claims for reimbursement
24 under the Medicare Program that the system

1 identifies as being potentially fraudulent, waste-
2 ful, or abusive.

3 (3) PROTECTIONS FOR PATIENTS AND PRO-
4 VIDERS.—The identification of an unusual or sus-
5 pect Medicare claim by the Prevention System
6 shall—

7 (A) not result in the denial of items or
8 services to an individual under the Medicare
9 Program until such claim is further reviewed by
10 the Secretary; and

11 (B) not result in a failure to comply with
12 prompt payment requirements under applicable
13 law.

14 (4) COMPLIANCE WITH HIPAA.—Any data col-
15 lected, stored, or reviewed under the Prevention Sys-
16 tem shall be treated in a manner that is in accord-
17 ance with the regulations promulgated under section
18 264(c) of the Health Insurance Portability and Ac-
19 countability Act of 1996 (42 U.S.C. 1320d–2 note)
20 and any other applicable law.

21 (e) TREATMENT OF DATA.—

22 (1) IN GENERAL.—The Prevention System shall
23 be a high volume, rapid, near real-time information
24 technology solution, which includes data pooling and

1 scoring capabilities to quickly and accurately capture
2 and evaluate data.

3 (2) DATA SOURCES.—The Prevention System
4 shall, for purposes of preventing fraud, waste, and
5 abuse under the Medicare Program—

6 (A) use data from claims for reimburse-
7 ment under the Medicare Program contained in
8 existing files of Medicare claims data, including
9 the Common Working File of the Centers for
10 Medicare & Medicaid Services; and

11 (B) to the extent practicable, pool data
12 from all available Government sources (includ-
13 ing the Death Master File of the Social Secu-
14 rity Administration).

15 (3) DATA STORAGE.—The Prevention System
16 shall be stored in an industry standard secure data
17 environment that complies with applicable Federal
18 privacy laws for use in building Medicare fraud,
19 waste, and abuse prevention predictive models that
20 have a comprehensive view of provider and supplier
21 activity across all markets, geographic areas, and
22 provider and supplier types.

23 (f) FRAUD MANAGEMENT SYSTEM.—

24 (1) IN GENERAL.—The Prevention System shall
25 utilize a fraud management system containing

1 workflow management and workstation tools to pro-
2 vide the ability to systematically present score, rea-
3 son codes, and treatment actions for high-risk scored
4 transactions, as determined under subsection (d).

5 (2) REVIEW OF CLAIMS.—The fraud manage-
6 ment system under paragraph (1) shall ensure that
7 analysts who review Medicare claims have the capa-
8 bility to access, review, and research claims effi-
9 ciently, as well as decline or approve payments on
10 claims in an automated manner.

11 (g) FEEDBACK LOOP.—

12 (1) IN GENERAL.—The Prevention System shall
13 utilize a feedback loop to gain access to outcome in-
14 formation on adjudicated Medicare claims so future
15 system enhancements can utilize previous experience.

16 (2) PURPOSE.—The purpose of the feedback
17 loop under paragraph (1) is to—

18 (A) enable the Secretary to measure—

19 (i) the actual amount of fraud, waste,
20 and abuse under the Medicare Program;
21 and

22 (ii) any savings to the Medicare Pro-
23 gram resulting from implementation of the
24 Prevention System; and

1 (B) provide necessary data to develop fu-
2 ture, enhanced models for use in the Prevention
3 System.

4 (3) ANALYSIS OF FINAL CLAIMS STATUS.—The
5 feedback loop under paragraph (1) shall analyze
6 data from all carriers to provide post-payment infor-
7 mation about the eventual status of a Medicare
8 claim as “Normal”, “Fraud”, “Waste”, “Abuse”, or
9 “Education required”.

10 (h) CLAIMS REVIEW PRIOR TO PAYMENT.—

11 (1) REVIEW BEFORE PAYMENT.—Subject to
12 paragraph (2), if a claim for reimbursement under
13 the Medicare Program is selected for review under
14 the Prevention System, the Secretary shall not make
15 a payment on such claim until such claim has been
16 reviewed under the system. In order to carry out
17 this paragraph, the Secretary shall ensure that ap-
18 propriate controls and technology are in place to as-
19 sess and measure the effectiveness of the Prevention
20 System, predictive models used under such system,
21 and the overall strategy for Medicare claims review.

22 (2) TIMELY REVIEW.—

23 (A) IN GENERAL.—The review of a claim
24 under the Prevention System shall occur in a
25 timely manner.

1 (B) APPLICATION OF PROMPT PAYMENT
2 REQUIREMENTS.—The limitation on payment
3 under paragraph (1) shall not interfere with the
4 prompt payment of a Medicare claim in accord-
5 ance with applicable law.

6 (3) MANUAL REVIEW.—If automated technology
7 presents a score, reason code, or treatment action
8 for a claim that is scored as “high-risk,” the Preven-
9 tion System shall provide for manual review of med-
10 ical records related to such claim by both clinical
11 and fraud investigators to ensure accuracy and miti-
12 gate false positive events.

13 (4) SELF-AUDIT REVIEW.—The Secretary may
14 use self-audit practices by providers and suppliers
15 under the Prevention System in a manner such that
16 once high-risk claims are identified through the pre-
17 dictive modeling, providers and suppliers are offered
18 the opportunity to adjust or withdraw their claims.

19 (5) DENIAL OF PAYMENT FOR FRAUDULENT
20 CLAIMS.—Under the Prevention System, if auto-
21 mated technology of a claim under paragraph (3)
22 and manual review under paragraph (4) confirm
23 fraud has occurred, the Secretary may deny payment
24 of such claim.

25 (i) ANNUAL ASSESSMENT REPORT.—

1 (1) IN GENERAL.—Not later than 2 years after
2 the implementation of the Prevention System, the
3 Secretary, through the Office of the Inspector Gen-
4 eral of the Department of Health and Human Serv-
5 ices, shall submit to Congress a report on the imple-
6 mentation of such system.

7 (2) CONTENTS.—The report submitted under
8 paragraph (1) may contain—

9 (A) a detailed assessment of the Preven-
10 tion System’s success in identifying fraud,
11 waste, and abuse;

12 (B) the costs of operating the Prevention
13 System; and

14 (C) an analysis of the overall return on in-
15 vestment for the Prevention System.

16 (j) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated to carry out this section
18 such sums as may be necessary.

19 (k) EXPANSION.—If the Secretary determines that
20 the Prevention System results in savings to the Medicare
21 Program, the Secretary shall expand the project through-
22 out Federal health programs, including the Medicaid Pro-
23 gram under title XIX of the Social Security Act and the

- 1 Children's Health Insurance Program under title XXI of
- 2 such Act.

